ARIZONA DEPARTMENT OF VETERANS' SERVICES
FIDUCIARY DIVISION

REFERRAL INTAKE INFORMATION

CHECKLIST OF REQUIRED ATTACHMENTS

			TITLE 14	EXPANDED TITLE 14
1.	Declination to Service from Relatives	Guardian/Conservator		
2.	Physician's Statement	Guardian Only		
3.	Human Service Specialist's Request	Conservator Only		
4.	This Form Completed	Social Security Number		
		VA Claim Number		

Referral Agency _____

County Eligibility No._____ Co. Code _____

Name of Potential Ward _____

Home Address _____

Current Address _____

Phone No. _____Sex _____ Race _____ Religion _____

No. of Years of County Residency _____ U.S. Citizen: Yes _____ No _____

Alien Status _____ Country _____ Date of Birth _____

Place of Birth: County _____ City_____ State_____

Language Barrier Yes _____No _____ No. of Years of Formal Education _____

Marital Status _____ Name of Spouse _____

Current Address of Spouse _____

If divorced or widowed, give date of event and place _____

Reason for Wardship _____

_____

Relatives or Friends (List in order: Parents, Adult Children, Next of Kin, Persons Having Care or Custody, Friends-Indicate if Deceased). Statement of inability or unwillingness to serve, as attached, or evidence of notification thereof, must accompany this form.

Relationship to Ward	Name	Address	Phone

To what extent does spouse depend on potential ward's funds for support? _____

_____

Does Ward have a Will? Yes___ No ___ Location of Will _____

Does Ward have burial arrangements? Yes ___ No ___

Location _____

Life Insurance Policies: Yes ___ No ___ Location _____

Company	Address	Policy Number	Beneficiary	Cash Surrender Value

Medical Insurance: (Including Medicare/Third Party Payor Policies/VA Coverage – give number and indicate Parts A and/or B – also date coverage began – type and percent of coverage.)

Company	Address	Policy Number	Location

Attending physician's statement form: (Name) _____
Address: _____Phone: _____

Financial Information on Potential Ward:

SOURCE	ACCOUNT #	AMOUNT	FREQUENCY RECEIVED	PAYEE
Social Security:				
SSI:				
VA:				
DFAS:				
Civil Service (CSF/CSA):				
Pensions or Annuities:				
Other:				

TOTAL AMOUNT MONTHLY: $_____

Financial Information on Spouse or Dependent Children:

NAME	SSA/SSI	VA	DFAS/CIVIL SERVICE	PENSION OR ANNUITIES	OTHER

TOTAL AMOUNT MONTHLY: $_____

INFORMATION ON VETERAN

Branch of Service: _____ Type of Discharge: _____

Service No.: _____ Grade: _____

Service Dates: From _____ To _____ VA Claim Number: _____

BANK ACCOUNTS	LOCATION (Name & Branch)	ACCOUNT # AND NAME	AMOUNT
Checking			
Savings			
Credit Union			
Safe Deposit Box (location of keys?)			
Bank Branch			

Co-signer, if any? _____

STOCKS, BONDS, AND OTHER SECURITIES, INCLUDING GOVERNMENT SECURITIES

	STOCKS	BONDS	SECURITIES
1. Name			
2. Address			
3. Value			
4. Number of Shares			
5. Policy Number			
6. Location			

REAL PROPERTY:

Street Address: _____

Parcel No. or Legal Description: _____

Title in the Name(s) of: _____

Mortgage: _____

Insured by: _____

Local Agent: _____

Value of Property in Dollars (per Assessor's Records): _____

Cars & Trailers Make & Model	VIN #	Title In Name(s) Of	Location of Title & Vehicle	Blue Book Value

Insurance with: _____

Policy Number: _____ Liens: _____

OTHER KNOWN ASSETS:

Type/Description (e.g., furniture, jewelry, electronics, size, color, etc.)	Serial/Model Number	Estimated Value

ADVS STAFF:

_____

Case Investigator Date

_____

Human Service Manager Date

_____

State Veterans' Fiduciary Date

REFERRAL SUBMITTED BY:

_____

Signature Date

_____

Address

_____

City, State Zip

_____

Phone

_____

Date

ARIZONA DEPARTMENT OF VETERANS' SERVICES
FIDUCIARY DIVISION

REFERRAL INTAKE WORKSHEET

Demographics:

Veteran's Name: _____ **Referred By:** _____

Residence: _____ **Referral's Phone #:** _____

Street Address: _____ **Reason for Referral:** _____

City, State, Zip: _____ **Physician's Name:** _____

Phone #: _____ **Physician's Phone #:** _____

SSN: _____ **Physician's Statement:** **Yes** ☐ **No** ☐

VA Claim #: _____ **Medical Insurance:** _____

Service Branch: _____ **Date of Birth:** _____

Service Dates: _____ **Place of Birth:** _____

Marital Status: _____ **Conservatorship:** **Yes** ☐ **No** ☐

Spouse: _____ **Guardianship:** **Yes** ☐ **No** ☐

Spouse SSN: _____ **Payee/Custodian:** **Yes** ☐ **No** ☐

Income:

SSA: _____ **SSI:** _____ **VA:** _____

CSF: _____ **Pension:** _____ **Other:** _____

Resources/Assets:

	Yes	No		
Checking:	☐	☐	**Bank & A/C #:**	_____
Savings:	☐	☐	**Bank & A/C #:**	_____
House:	☐	☐	**Address:**	_____
Trailer:	☐	☐	**Address:**	_____
Land:	☐	☐	**Address:**	_____
Car:	☐	☐	**Make/Model:** _____	**VIN#:** _____
Other:	☐	☐	_____	

Family/Contact Persons:

Name	Relationship	Phone #	Address

ARIZONA DEPARTMENT OF VETERANS' SERVICES (ADVS)

PHYSICIAN'S STATEMENT IN SUPPORT OF TITLE 14
GUARDIANSHIP AND/OR CONSERVATORSHIP

PATIENT'S NAME: _____

I, _____, the personal physician of the above-named patient, submit this report to ADVS supporting my opinion of the need for appointment of a guardian and/or conservator. I have been the patient's physician since _____ and saw this patient most recently on _____.

1. I am a licensed physician and am authorized to make this statement. My area of specialty is _____. I □ am □ am not Board Certified in this area. I am also Board Certified in the following area(s). _____
_____

2. I examined the patient on _____ in connection with the preparation of this report.

3. The patient has difficulty in the following area(s): □ mental illness or disorder; □ physical illness; □ chronic intoxication or drug abuse; □ cognitive abilities; □ other. Check all that apply and explain. _____
_____
_____

4. The patient's primary diagnosis supporting a guardianship and/or conservatorship petition is _____. The patient has been suffering from this condition since _____ and □ has □ has not previously been treated or hospitalized for this condition.

5. The patient is limited in the following abilities due to his/her condition: □ to pay bills; □ to obtain food; □ to provide adequate housing; □ to perform daily self-help skills; □ to live alone; □ to take medication appropriately; □ to drive a motor vehicle □ to make appropriate judgments that will protect the patient personally, physically, or financially.

6. The medications for which the patient is presently prescribed are: _____
_____
_____

7. I □ do □ do not believe the medication is affecting the patient's ability to respond coherently.

8. I □ do □ do not believe the medication is affecting the patient's ability to ambulate.

9. I □ do □ do not believe a "medication holiday," if possible, would help better evaluate this patient.

10. I □ do □ do not believe any changes made in the type or amount of drugs the patient is receiving would noticeably affect their mental or physical abilities.

11. I □ do □ do not believe further medical evaluation or treatment would benefit the patient. Explain. _____

_____

_____

12. I □ do □ do not believe the patient would benefit from other types of therapy such as counseling. Explain. _____

_____

_____

13. It is my belief the patient should be living: □ at home with a companion; □ at home with a nurse; □ in a group home; □ in a boarding home; □ in a supervisory care facility; □ in a nursing home; □ in a hospital; □ in a level one behavioral health facility for inpatient mental health treatment (if checked, complete pages 3-4 of 4); □ other (please explain).

_____

_____

_____

14. Based on the patient's condition described above, it is my opinion that the patient is **GRAVELY DISABLED** and requires the **EMERGENCY** appointment of a **TEMPORARY GUARDIAN**: □ **YES** □ **NO**

15. Based on the patient's condition described above, it is my opinion that the patient requires the appointment of a **GUARDIAN** as the patient is unable to make and communicate responsible decisions concerning his/her person: □ **YES** □ **NO**

16. Because of the patient's condition described above, it is my opinion that the patient requires the appointment of a **CONSERVATOR** as the patient is unable to manage his/her property and affairs effectively, which property is needed for his/her care, support, and welfare: □ **YES** □ **NO**

17. I □ do □ do not believe that the patient's condition will improve within six months to a year.

18. I □ do □ do not believe that this matter should be reviewed by the Court within six months to one year.

19. Following are additional comments or suggestions I think would be helpful to the Court in making its decision. _____

_____

_____

_____

Dated: _____

_____
Signature of Physician

_____
Physician's Typed/Printed Name

Mental Health Treatment Issues (This page must be completed when requesting authority to consent to inpatient mental health treatment. Refer to question 13 on page 2 of 4)

1. Is it opinion of the undersigned that the patient is incapacitated as a result of a mental disorder? □ **YES** □ **NO**

2. What is the mental disorder? _____

3. Is it the opinion of the undersigned that the patient is currently in need of inpatient mental health care and treatment? □ **YES** □ **NO** (For the purpose of this question, the term "currently" means, based upon the medical professional's experience and training, and to a degree of medical probability, the patient does now or will within a reasonably imminent and immediate time require inpatient mental health treatment.)

4. In the event the answer to #3 above is "Yes," please explain the need for, and the anticipated onset and duration of, the inpatient treatment. _____

5. What kind of treatment is the patient currently receiving for this disorder? _____

6. Give a comprehensive assessment of any functional impairments of the patient. _____

7. How, and to what extent, do these impairments affect the patient's ability to receive or evaluate information needed in making or communicating personal and financial decisions? _____

8. What task of daily living is the patient capable of performing without direction or with minimal direction? _____

9. What is the most appropriate rehabilitation plan or care plan for the patient? _____

10. What would be the least restrictive living arrangement reasonably available for the patient? _____

_____

_____

_____

11. Is there any reason why this patient should not personally appear in court? □ **YES** □ **NO**
If "yes," please explain. _____

_____

_____

_____

12. Please make any additional comments or suggestions you feel would be valuable to the court. _____

_____

_____

_____

Dated: _____

_____
Signature of Physician

_____
Physician's Typed/Printed Name

ARIZONA DEPARTMENT OF VETERANS' SERVICES
FIDUCIARY DIVISION

(Concurrence In Favor of ADVS Appointment)

To Whom It May Concern:

Re: _____

I, the undersigned _____ of _____ acknowledge that said person's mental or physical condition necessitates the appointment of a Guardian and/or Conservator. I further understand that as the _____ of _____, I have or share priority to serve in such capacity, but I am not able or willing to do so.

I further understand that the expenses involved in assuming the Guardianship and/or Conservatorship may be recovered from the estate of the Protected Person if such expenses are properly accounted for and if the estate can bear such expense.

Having been made aware of the above statements, I have come to the decision that I am unable or unwilling to serve as Guardian and/or Conservator for _____ and hereby request that the Arizona Department of Veterans' Services, Fiduciary Division, be appointed as Guardian and/or Conservator.

I further agree that I will not serve as payee for any veteran's, social security, retirement, pension, disability, or other benefits accruing _____, and hereby waive my right to serve during the term of this Guardianship and/or Conservatorship.

The undersigned swear or affirm that the statements set forth above are true and correct, subject to the penalties of making a false affidavit or declaration.

DATED: _____

_____
Signature

_____
Printed Name

_____
Address

_____
Telephone Number

JANET NAPOLITANO
GOVERNOR

STATE OF ARIZONA
DEPARTMENT OF VETERANS' SERVICES
FIDUCIARY DIVISION
FAIRMOUNT ON THIRD
3839 NORTH THIRD STREET, SUITE 100
PHOENIX, ARIZONA 85012-2068
TELEPHONE: (602) 248-1554 FAX: (602) 248-1557
STATEWIDE: (888) 248-1554

PATRICK F. CHORPENNING
DIRECTOR

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

I, _____ _____
Name of Patient Social Security #

_____ authorize _____
Date of Birth Hospital or Program making decision

to disclose to _____
Name & Address of Hospital/Organization to which disclosure is to be made

_____the following information:

_____

_____

_____

_____

_____

_____

_____

_____

_____

Purpose or need (how information is to be used):_____

_____

Executed this ____ day of _____, 20__.

_____
Signature of Guardian/Authorized Representative